Psychiatry-UK LLP

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Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Our rating of this service went down. We rated it as requires improvement because:

- While staff assessed and managed risk once patients were on their caseload, the system was inconsistent and lacked standardised risk assessment tools.
- Staff mostly followed good practice with respect to safeguarding but there were inconsistencies and areas for improvement that senior leaders and governance systems had not identified.
- The provider did not have sufficient oversight of the risks relating to clinicians providing remote care, including the availability of on-demand emergency support and assurance of confidential working environments.
- Medicines management systems did not include sufficient prescription tracking capabilities to provide assurance of security and there was no audit system in place to manage risk.
- Governance systems, including for incident reporting and management, had not kept pace with the growth of the service. This meant there were gaps in assurance of risk management and the capacity of the senior leadership team to safely manage the service.
- There was a lack of evidence the provider acted on feedback from staff in the annual survey to improve working practices and address concerns.

However:

- The service provided safe care once patients were assessed and in a treatment plan.
- Staff worked well with multidisciplinary organisations to coordinate care for patients living with comorbidities and complex needs.
- Staff described good working relationships and on-demand support in a positive, collaborative culture.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community-based mental health services for adults of working age	Requires Improvement 	Our rating of this service went down. We rated it as requires improvement because: • The number of patients referred to the service significantly exceeded capacity. Waiting list governance and management systems were insufficient to ensure staff could provide appropriate care to patients at risk of deterioration. • Systems to manage patient risk when they could not be contacted were limited and did not provide assurance of safety and good practice. • There were significant gaps in accountability for the welfare of patients who were waiting for assessment after a referral. There was no structured understanding between the providers involved in each patient's care regarding this period of waiting, which led to patients 'lost to follow up' and lengthy delays in the provider's reporting of patients who died whilst on a waiting list. However: • The provider had recognised the risks associated with the increase in demand and had implemented a wide-ranging series of plans and strategies to address them, including a wholesale restructure of the organisation and senior leadership team. • Standards of training and professional development reflected the needs of staff and patients.
Specialist community	Inspected but not rated 	We have not previously inspected the children and young people service. We have not rated the service and instead provide a narrative report.

Summary of findings

mental health services for children and young people

Our key findings were:

- The service provided safe care. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.
- Staff developed holistic care informed by a comprehensive assessment and in collaboration with families. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients.
- Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood the principles underpinning capacity, competence, and consent as they apply to children and young people and managed and recorded decisions relating to these well.

However:

- Risk assessment processes were inconsistent, both during patient treatment and as part of governance processes.
- While safeguarding standards overall were good, there were inconsistencies in documentation and communication relating to ongoing safety and care.

Summary of findings

Contents

Summary of this inspection

Background to Psychiatry-UK LLP

Psychiatry-UK LLP is the name of the service, provider, and registered location. The service provides consultant-led mental health care and treatment for adults living with attention deficit hyperactivity disorder (ADHD) and other conditions such as autism spectrum disorder and mood disorders. A team of prescribing nurses provide titration treatment. ADHD care is provided to NHS patients through commissioned contracts, some of which operate on a 'right to choose' basis and the service provides a range of mental health services to private patients. Right to choose is a national initiative that enables patients to opt for a specific service or provider once they are referred to a specialty by a GP or other NHS professional.

The service also provides dementia assessments to older people through an NHS commissioning arrangement for one trust. Treatment for ADHD forms most care provided, and services are delivered nationally, including in Cumbria, Northumberland, Essex, Berkshire, and the Isle of Wight.

The service provides remote assessment and titration services for children and young people (CYP) living with attention deficit hyperactivity disorder (ADHD) through NHS child and adolescent mental health services (CAMHS) contracts, 1 of which was for diagnostics. Commissioned services formed part of wider clinical pathways. For example, under 1 contract the service diagnoses conditions and titrates medicines then refers the patient back to the NHS trust. The service also provides mental health diagnostic and treatment services privately for self-paying or insured patients.

The service provides CYP care to patients aged from 7 years old to 18 years old. While there is no formal transitional care pathway in place where patients still require care when they become 18 years old, the service liaises with NHS commissioners to arrange continuity of care.

The service registered with us in December 2020 at its current address to provide the following regulated activity:

- Treatment of disease, disorder or injury

There is a registered manager in post.

The service does not operate from clinical premises and all care is delivered using digital tele-conference software. Clinicians meet patients virtually from home offices and patients join appointments online from their choice of location.

We last inspected the service in March 2020 and rated it good overall.

The provider's main service was community-based mental health services for adults of working age. Where our findings on CYP – for example, management arrangements – also apply to the main service, we do not repeat the information but cross-refer.

Following the inspection, we took immediate action to ensure regulated activities could be delivered safely. This resulted in the provider suspending acceptance of new referrals through the NHS 'right to choose' system and the implementation of a waiting list management plan.

Summary of this inspection

How we carried out this inspection

We carried out an announced, focused inspection of the service on 16 and 17 August 2023 from a CQC office. This included in-person interviews with most of the provider's senior leadership team and with others remotely by videochat. We interviewed consultants, registered nurses, and non-clinical staff remotely. We carried out an unannounced inspection of the provider's registered location head office on 18 August 2023. We included only the safe and well-led domains in our inspection.

Our inspection team included a lead inspector, 2 CQC pharmacists and a nurse specialist advisor with support from 3 operations managers and a mental health specialist.

All care is delivered remotely by videochat software, and all patient records are digital. We announced the inspection so that we had access to the evidence we needed to make a judgement as well as access to the members of staff with whom we needed to speak. The provider's registered address is used for administration and document management, and we included this in our inspection so we could speak with staff and understand administrative processes involved in the quality and safety of care.

After our inspection we spoke with several staff remotely and reviewed evidence submitted to us by the provider.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

- The chief technology officer (CTO) and a team of multidisciplinary colleagues were developing a significant, transformational digital programme of work to improve patient care and provider capacity. Work included proof-of-concept testing for clinical artificial intelligence systems at the leading edge of international mental health care development. Technology-led improvements planned for the service took place within clear safety and data protection policies and systems.
- The provider operated nationally and recognised the regional differences in policies and standards of practice across NHS trusts and integrated care systems. Staff worked opportunistically and shared good practice with colleagues across organisations. This contributed to an overarching care culture that promoted innovation, idea-sharing, and learning from the good practices of others. Such work led to new developments in shared care pathways, which significantly improved patient outcomes.
- The provider recognised the pressures on staffing mental health services nationally and the restrictions caused by traditional models of care. To address this, staff partnered with universities and royal colleges to create training and development opportunities for professionals not typically involved in mental health care, such as junior doctors and specialist registrars.

Summary of this inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

Community-based mental health services for adults of working age

- The service must ensure waiting lists are managed safely and effectively and that senior staff have a clear understanding of patient risks. (Regulation 12)
- The service must ensure that risks associated with providing care and treatment out of hours and led by consultants outside of the UK are consistently and effectively managed. (Regulation 12)
- The service must ensure patients who experience extended waits for treatment are appropriately managed for risk. (Regulation 12)
- The service must ensure patient risk assessments are carried out consistently and are individualised. (Regulation 12)
- The service must ensure known safeguarding risks are followed up and/or acted upon when patients disengage and cannot be contacted. (Regulation 12)
- The service must ensure risk management, quality assurance, and clinical governance systems are fit for purpose and meet the needs of patients and staff. (Regulation 17)
- The service must ensure auditing systems have the capability to manage the security assurance of prescriptions sent by individual consultants to patients and pharmacies. (Regulation 17)

Action the service SHOULD take to improve:

Community-based mental health services for adults of working age

- The service should ensure there are mechanisms in place to learn from near misses. (Regulation 12)
- The service should ensure staff working in head office have fire safety training and the building has suitable emergency signage. (Regulation 12)
- The service should ensure consultants complete patient records in a timely manner after assessments. (Regulation 12)
- The service should ensure organisational accountability for patients who are waiting for assessment or treatment are clearly defined. (Regulation 17)
- The service should ensure there is assurance of confidentiality for patients who receive care from clinical staff working from home. (Regulation 17)
- The service should ensure training is tailored to staff roles and responsibilities. (Regulation 18)

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community-based mental health services for adults of working age	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement
Specialist community mental health services for children and young people	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement

Community-based mental health services for adults of working age

Requires Improvement

Safe	Requires Improvement
Well-led	Requires Improvement

Is the service safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Safe environment

Staff delivered care and treatment remotely using digital software accessed from a location of their choice. The provider had limited assurance of the suitability and confidentiality of such environments.

Clinicians delivered care remotely, usually from a home office. While the provider had a policy that established criteria for the working environment, such as an enclosed space to ensure confidentiality, there were no audits or systems to provide assurance. Staff worked on an honesty basis and the provider did not carry out checks or risk assessments of the suitability or security staff working environment. This meant there was no assurance staff worked from an appropriate space that afforded patients confidentiality during appointments.

A dedicated administration team worked from the provider's head office. The team processed hard copy confidential patient documentation, such as referrals or discharge letters sent by post, and dispatched prescription pads to clinical staff at their home address. Staff used good systems to manage confidential documents and kept prescription pads in locked storage with restricted access. The premises were protected with security systems, including digital restrictions for access to electronic records.

While security and safe storage were of a good standard in the provider's head office, there was a need for improved fire safety. For example, there was a lack of emergency signage to fire exits and staff did not have a clear understanding of the location of fire extinguishers.

Safe staffing

The service had enough staff, who knew the patients and received basic training to keep them safe from avoidable harm once treatment commenced. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. However, overall demand significantly outstripped capacity.

The service had enough clinical staff to keep patients safe from harm once they had been assessed and treatment commenced. However, a lack of clinical staff overall meant waiting times from referral to assessment and then to the commencement of treatment had increased significantly.

Community-based mental health services for adults of working age

Requires Improvement

The service had a continual programme of recruitment, which reflected substantial and persistent increases in referrals and demand. Staff numbers had increased by 69% in the previous 12 months as the provider expanded and reorganised. This was an average figure that included a 77% increase in permanent staff reflecting a new staffing strategy to move the provider away from a reliance on self-employed staff. At the time of our inspection the service had 19 vacancies for permanent staff and recruited continually for self-employed contractors.

The provider used a team-based clinical model to deliver care, which included consultant psychiatrists, assistant psychologists, occupational therapists, speech and language therapists and registered mental health nurses. All staff completed an induction process before they delivered care unsupervised. Clinicians rated this variably in the 2023 staff survey. Of those who took up their post in the previous 12 months, 66% rated the induction excellent or good. Feedback indicated wide variances in how new staff engaged with the digital nature of care delivery and the remote staffing structure. There was limited assurance the provider had consistent, substantive structures in place to support staff who found the unfamiliar way of working challenging.

A dedicated administration and operations team provided support and staffed a point of contact phone number for patients and referrers. Most consultants and nurses were self-employed subcontractors. The provider ensured they held appropriate UK registration and carried out background and qualification checks on each along with in-house training. Clinical staff then worked as and when they were available. Most members of the team also worked substantively in NHS services, which meant they were up to date with the latest treatment guidance and understanding.

As clinical staff were self-employed and worked hours based on their own availability and other commitments, the service did not monitor traditional staffing measures such as sickness and turnover, although they reported a monthly attrition rate of between 0% to 8% in the previous 12 months. Clinical directors, administrators, and members of the senior leadership team were permanently employed.

Nurse prescribers completed the titration process with patients after consultants completed assessments and diagnosis. This was a collaborative process and clinical staff worked together to agree on the most appropriate treatment for each patient.

A team of 12 liaison nurses managed the needs of patients with complex needs and triaged referrals received for patients living with attention deficit hyperactivity disorder (ADHD) through NHS commissioned pathways.

A dedicated team of administration and operations staff were based in the provider's registered address. They processed incoming referrals, confidential printed prescription materials, hard copy treatment plans and discharge letters. This team along with colleagues who worked remotely ensured consistent standards of administrative support and good communication across the provider.

Senior clinical staff provided regular supervision sessions on request or after any incident. Each nurse prescriber had a named consultant for clinical support and supervision.

Medical secretaries provided administrative support to groups of consultants based on factors such as their number of weekly hours and number of patients. This was a flexible, dynamic system that meant the team provided support proportionately based on need.

Community-based mental health services for adults of working age

Requires Improvement

The chief people officer and chief technology officer had developed new contracts enabling clinical staff to be directly employed by the provider if they wished. Along with new weekly minimum hour guidelines for consultants, the senior team offered incentives for clinicians to join the service on the new contract, which they designed to provide more stability and predictability around available hours of care. This formed part of a wider strategy to increase capacity and reduce waiting times.

The provider used a safer recruitment policy to ensure all staffing complied with national requirements. This included an up-to-date Disclosure Barring Service (DBS) check, 2 professional references, and verified qualifications. We checked a sample of staff records during our inspection, all of which included appropriate documentation and evidence. While staff often delivered remote care from international locations, they all held current UK registration.

Consultants held registration on the specialist register of the General Medical Council (GMC) and nurses held registration with the Nursing and Midwifery Council (NMC). The medical director carried out annual GMC appraisal checks for each consultant to ensure they remained fit and able to provide care. Each consultant was part of a peer group, most of which were based in a Royal College. This ensured they were part of continual review and professional development.

Mandatory training

Staff completed and kept up to date with mandatory training, which was comprehensive and met the needs of patients and staff. Mandatory training was delivered online and included up to 21 modules depending on staff role. Training reflected the nature of the service and included unconscious bias, conflict resolution, digital systems, data security, the Mental Capacity Act 2005, and the Mental Health Act 2007.

New staff completed their training fully along with a probationary period before working unsupervised with patients.

Managers monitored mandatory training and alerted staff when they needed to update their training. The senior team used a good system to monitor training completion that reflected the complexities of the staffing structure. For example, managers tracked the training completion of consultants who worked occasional hours and outside the UK.

Clinicians rated the provider's training package variably in the 2023 staff survey. Of those who took up their post in the previous 12 months, 61% rated the training excellent or good. More broadly and in the same survey, 70% of clinicians said they felt training and opportunities for continuing professional development were excellent or good.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients although did not follow a standardised process. They responded promptly to sudden deterioration in a patient's health during sessions. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff did not consistently monitor patients on waiting lists to detect and respond to increases in level of risk. The provider had limited understanding of risks to staff.

Assessment of patient risk

Referring clinicians completed a screening tool prior to submitting a referral request to ensure the service was appropriate for the patient's needs. Nurses then triaged each referral and carried out an initial screening and brief risk assessment for each patient. The patient then entered a waiting list for an assessment by a consultant. This system did not fully enable staff to understand potential risks to patients, such as those referred inappropriately or with missing information about their level of need. In addition, staff did not screen, or risk assess, all referred patients promptly as referrals outstripped capacity.

Community-based mental health services for adults of working age

Requires Improvement

Staff used a standard operating procedure to ensure referring clinicians included appropriate documentation for each patient. This included a completed screening tool with a score, such as the autism spectrum quotient 50 (AQ50), medical summary, a referral letter, and supporting information. Where patients had a history of contact with mental health services, staff asked for historical treatment and prescribing information to ensure assessments and treatment plans were safe and appropriate.

The service was improving how quickly staff could screen referrals for this information but at the time of our inspection many thousands of patients were still waiting over 12 weeks for this process to take place. Patients had the details of a single point of contact during this period, who provided advice and guidance on other services available and potential wait times.

Consultants completed a narrative risk assessment for each patient at their first appointment and reviewed this regularly, including after any incident. There was no standardised risk assessment template or system and instead consultants assessed risk based on their own usual professional practices. All 23 of the patient records we reviewed included a narrative discussion of risk, but this was detailed within lengthy sections of notes and transcribed conversations. This meant the provider did not have continuous, readily accessible oversight of risks relating to specific patients. While consultants provided handovers to colleagues to ensure continuity of care when they were away from work, the lack of a standardised system meant there were gaps in the consistency of risk assessment and management.

Staff considered non-biological therapies when assessing patient care and risk. For example, they reviewed clinical information submitted with referrals and assessed the implications of other health risks, such as cardiology treatment. Where biological treatment for mental health conditions would increase risk in other medical areas, consultants liaised with the referring professional to coordinate access to the most appropriate alternative treatment.

At the beginning of each session, the clinician confirmed an identity check with each patient and asked for their location. The service implemented this process after finding patients sometimes joined online calls from public spaces such as coffee shops. In such cases staff reviewed confidentiality risks with the patient.

Documentation of patient risk was inconsistent. For example, a consultant had documented a patient had no known risks but elsewhere in their record noted recent substance misuse that contributed to their current mental health problem. This reflected the wide variety of different approaches to risk assessment without a standardised tool.

Management of patient risk

Staff used a generic crisis plan if patients deteriorated whilst under their care or in circumstances such as when patients disclosed suicidal intent. In emergencies staff called 999 and tried to keep the patient connected to the videocall until emergency services arrived. While this was appropriate for the non-urgent nature of the care provided, it did not fully consider the potential a patient's need had increased during lengthy waits for assessment. The provider did not have a system to monitor if a patient became unwell whilst waiting. The initial screening tool was not included in clinical notes, which meant consultants had an incomplete understanding of cumulative risk.

Staff did not continually monitor patients on waiting lists for changes in their level of risk. While the provider recognised this as an urgent matter, the increase in patients waiting significantly exceeded capacity and staffing. To address this, a new liaison nurse team worked to review waiting patients and provide points of contact in the event they experienced a crisis.

Staff personal safety protocols in the event a patient was abusive or threatening. The safeguarding lead arranged follow-up and support for staff who experienced this and ensured they received appropriate help.

Community-based mental health services for adults of working age

Requires Improvement

Consultants completed cardiac risk forms before completing a treatment plan that included titration. Most NHS patients received treatment under shared care arrangements, which meant the service worked with GPs to make sure care was coordinated, appropriate for individual needs, and timely.

Consultants held multidisciplinary meetings with colleagues and referring clinicians to coordinate care for patients with complex needs, such as when other specialist input was needed. Liaison nurses connected with multidisciplinary providers to support patients waiting lengthy periods for treatment.

Staff used a managing crisis policy to get help urgently during a patient appointment, such as if a patient discussed self-harm or suicidal intent. This included an online system to summon urgent help from a senior colleague. While this system worked well most of the time, there were gaps in assurance for patients with immediate need. For example, some consultants provided appointments from outside of the UK in different time zones. This met patient requests for out of hours appointments, especially late evening appointments, but meant there was no live, on-demand senior support available from the provider. We raised this as a concern with the provider after our inspection. In response the senior leadership team implemented new working protocols for staff delivering care from outside of the UK that meant there would always be a point of contact for them in an emergency.

The provider had introduced the nurse liaison role to better manage patient risk whilst they waited for treatment. This team also identified gaps in support for patients with more complex needs such as depression and anxiety. Nurses worked individually with patients to provide holistic care and involved other agencies to support this, such as improving access for psychological therapies (IAPT) practitioners in community NHS services. Liaison nurses did not carry a defined caseload and instead responded as needed to increased risk with individual patients.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role and the provider ensured they stayed up to date. The safeguarding team provided training to all staff. They worked with non-clinical frontline staff to help them identify potential safeguarding needs and risks during initial patient contact. Clinical staff were trained to safeguarding level 2 and senior staff to level 3. The safeguarding lead had level 4 training. All staff completed national 'PREVENT' training to level 3, which provided tools to recognise signs of radicalisation.

A dedicated safeguarding lead and a support officer maintained continual oversight of safeguarding concerns and referrals. They acted as points of contact for staff, including for urgent concerns and escalation. The nursing team took a lead role in managing care for patients with known safeguarding risks, including those with suicide ideation or previous suicide attempts. The team coordinated multi-agency care for these patients with other providers and ensured full handovers took place if the level of care needed was beyond the scope of the service.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Liaison nurses worked with patients to signpost them to community organisations that could support with needs or inequalities relating to protected characteristics.

Staff knew how to recognise adults at risk of or suffering harm and worked with other agencies to protect them. For example, where staff found evidence of abuse or neglect, they worked with the safeguarding lead and specialist community services to secure support for the patient. This included examples of domestic violence and coercion and reflected good practice.

Community-based mental health services for adults of working age

Requires Improvement

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff had access to the contact details of the responsible local authority's safeguarding team for each patient.

Staff spoke highly of the safeguarding team and provided examples of how they worked together to obtain support for patients whose condition deteriorated or who experienced a crisis during an assessment. This included liaison with local authority crisis teams and emergency services.

Liaison nurses worked with primary care teams and local authority safeguarding teams to manage risks of patients with complex needs, including those with historic experiences of domestic abuse and self-harm.

The safeguarding lead proactively maintained links and membership with groups and boards nationally, including a safeguarding practitioner forum. This meant they were always up to date with changes in guidance and recommended practice. Such work provided opportunities for learning from investigations and incidents shared by other providers.

Clinical staff underwent regular safeguarding supervisions that involved case studies and learning from experiences and incidents. The safeguarding lead used this system to implement policy changes. For example, the service made a new requirement for patients to disclose the names of any children and young people normally resident with them. This followed an instance in which a clinician found children to be at risk of harm, but the local authority had no awareness of who they were.

The safeguarding team made an average of 140 alerts per month and shared themes and trends with the senior leadership team as part of clinical governance. Instances of suspected coercive control were an increasing theme amongst incidents and the safeguarding team worked with clinicians, senior colleagues, and GPs to coordinate patient support. Staff were proactive in escalating concerns. For example, administrative staff reported if they heard unexpected voices instructing patients during phone calls and clinicians reported instances of seeing unexpected people in the background of video calls. Such attention to detail helped ensure vulnerable patients were kept safe.

Staff were skilled in identifying safeguarding risk factors and established a wealth of knowledge of the differences in common risks between NHS and private patients. In instances where they were concerned about the controlling behaviour of the spouses of private patients who tried to dictate treatment plans and prescriptions, they stopped treatment and liaised urgently with GPs or the police.

Staff access to essential information

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care.

Patient notes were comprehensive, and relevant staff could access them easily and securely. All notes were electronic, and each patient had a care and treatment record that included narrative assessments and screening tools. Records were stored in an encrypted system with controlled access and back-ups in place in the event of a systems error.

Consultants provided timely information and recommendations to referring GPs where they could not proceed with a patient's treatment.

Clinical staff had access to the records of their own patients, with a sharing function when they required consultation with colleagues. This ensured each consultant or nurse had ownership and accountability for the records of patients under their care. Consultants provided formal handovers to colleagues for continuity of care during times away from work such as annual leave.

Community-based mental health services for adults of working age

Requires Improvement

Consultants did not always complete records in a timely manner. In 1 record we looked at a consultant completed patient notes 15 days after their assessment. In another record, a consultant completed an assessment letter 1 month after they saw the patient. There was no auditing system in place to identify delays in completing patient assessment records, which meant there was no assurance such delays did not contribute to increased risk.

Staff confirmed three points of identity with patients at the beginning of each appointment, as well as the patient's most up to date weight and height measurements.

When patients transferred to a new team, there were no delays in staff accessing their records. For example, consultants provided detailed handovers to GPs and referring clinicians when coordinating multidisciplinary care or discharging patients.

Medicines management

The service used systems and processes to safely prescribe medicines, although there was room for improvement in risk management. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe medicines safely. Consultants and prescribing nurses followed national guidelines in medicine titration. Medicines and titration leads provided oversight and support to prescribing staff and liaised with referrers and NHS trusts to navigate regional differences in prescribing guidance and restrictions.

The provider's standard operating procedure required staff to prescribe medicine within 48 hours of a consultant completing a treatment plan. However, the titration team sometimes received diagnoses and patient assessments significant periods of time after they had taken place. To ensure titration remained appropriate and safe, nurses contacted patients and their GPs to update records, such as with any new medicines and any change in their health status. This formed part of a risk assessment process to ensure prescribing took place safely and appropriately. For example, the service required each patient's GP to carry out the physical health monitoring required for specific medicines, such as blood pressure and weight checks. Where GP practices would not carry out ongoing monitoring, staff made alternative arrangements, such as prescribing blood pressure monitoring equipment for the patient to take home.

Prescribing was a collaborative process and staff made sure patients consented to the proposed treatment plan and that their GP approved prior to commencing. Patients chose their preferred pharmacy to collect medicines in advance of the first prescription being issued.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff completed medicines records accurately and kept them up to date. When a patient was stable with a medication plan, staff discharged them from the service back to the referring clinician. They followed up with the patient 12 months after discharge to review their treatment stability and any additional needs.

The service had a standard operating procedure to continue medicines management for individual patients where the referring clinician was not able to prescribe their titration medicines. For example, where a patient's GP would not prescribe medicines initiated by this service, consultants worked with NHS contract managers to continue the treatment plan directly, without the usual discharge back to the referrer.

Staff prescribed medicines only where patients were registered with a GP. Where patients requested a prescription and staff could not verify the GP, they discontinued treatment. In such cases staff documented their assessment and explained to patients why they could not safely continue. Staff told us this most often happened with private patients who self-referred and the requirement for a registered GP helped to reduce the risk of inappropriate and unsafe prescribing.

Staff stored and managed prescribing documents in line with the provider's policy. A dedicated administration team based in head office distributed prescription pads securely to prescribers at their home address. The administration team kept a record of prescription slip reference numbers and the clinicians to whom they were sent. Prescribing staff stored slips at home and were required to store them securely in a locked area although the provider did not have an assurance system in place for this.

Staff followed national practice to check patients had the correct medicines before discharging them back to the referrer for ongoing or shared care. There were no national guidelines for the treatment of ADHD and instead the service developed internal care frameworks based on best practice guidance from the National Institute for Health and Care Excellence (NICE). Consultants documented where they prescribed outside of the guidelines although there was limited auditing and oversight of this from the senior team. For example, while learning and multidisciplinary updates about unusual or out of guideline prescribing was shared with clinical staff through newsletters and e-mails, there was no system in place to identify themes and trends.

The clinical director reviewed national patient safety alerts and updated policies and guidance in response.

The service ensured patient's behaviour was not controlled by excessive and inappropriate use of medicines. Staff documented decision-making discussions in treatment plans, including where they identified a safety rationale for not prescribing medicines. The service followed NHS England's national STOMP-STAMP (stopping over medication of people with a learning disability, autism, or both and supporting treatment and appropriate medication to paediatrics) guidance as part of the policy to avoid excessive prescribing.

Staff printed and signed prescriptions and posted them using a tracked service to the patient's chosen pharmacy. Tracking of prescriptions was inconsistent, and some prescribers maintained their own records rather than using the provider's centralised system. Patients were required to confirm receipt of medicines using the electronic records system. While they provided it on request to the provider, the different processes in use meant there was no reliable overarching tracking system to ensure prescriptions were sent and received by the appropriate people.

Staff documented conversations with patients about medicine side effects and how to report them, including use of the national yellow card reporting system. Staff did not prescribe some medicines, such as lithium and valproate because the nature of the service meant they could not monitor blood results before and during treatment in line with national guidance. Where consultant assessments found patients would benefit from such treatment, they referred them directly to another mental health provider or to their GP.

All 8 records we checked reflected good standards of prescribing documentation. Staff made comprehensive, timely notes about prescribing decisions and highlighted when patients presented with additional risks. Staff prescribed within the medicines management policy and the prescribing standard operating procedure, both of which were up to date and reflected changes in national guidance.

Track record on safety

The service had a good track record on safety.

Community-based mental health services for adults of working age

Requires Improvement

Staff reported no serious incidents or incidents with patient harm in the previous 12 months.

While there had been no serious incidents involving patients directly receiving care, we received statutory notifications from the provider regarding people who had died by suicide in the period between being referred to the service and beginning care. There was a lack of understanding over which organisation held accountability for the safety of patients in this circumstance as they were still under the substantive care of the referring service.

The provider reported such incidents to under their legal obligations but took several months to do so. The investigation found a significant number of patients 'lost in the system' due to a change in IT processes, some of whom had been referred over 18 months previously. The provider and made urgent contact with each individual. The senior team implemented new measures to ensure the incident was not repeated. While such learning reflected good practice, there was limited evidence the provider made persistent attempts to contact patients or their referrers when they did not respond to initial messages.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents although there was limited assurance they consistently shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. They raised concerns and reported incidents and near misses in line with the provider's policy. While there was an incident reporting system in place, this required staff to e-mail a manager, who then entered details onto a spreadsheet and analysed the information manually to identify trends. This system did not meet the needs of the service as it expanded rapidly, and the senior leadership team were in the process of implementing and embedding a new centralised incident reporting system. This would bring the service in line with the Patient safety incident response framework (PSIRF) system used nationally by the integrated care boards (ICBs) and enable staff to identify changes in incident patterns.

Staff understood the duty of candour and the provider had a clear policy and training. However, some staff felt the provider did not act quickly on issues relating to the duty of candour and said colleagues did not always follow best practice.

Managers debriefed and supported staff after any serious incident. Most incidents involved threats of self-harm from patients, or inappropriate behaviour towards staff. In such cases the safeguarding lead worked with staff to ensure they had the support they needed. Clinical leads worked with consultants and nurses to adapt treatment plans as part of incident outcomes if this would reduce future risk.

There was limited evidence staff consistently received feedback from investigation of incidents, both internal and external to the service. While the incident lead analysed incidents for themes and trends and the risk manager attended all incident review meetings, most staff we spoke with did not know about recent incidents and could not tell us about any learning. This meant there was limited assurance the existing system was fit for purpose. Senior staff said they discussed incident themes in team meetings and communicated them to all staff through the newsletter.

There was limited evidence the service proactively and consistently made changes as a result of learning from incidents. For example, the provider had not implemented safer ways of working for consultants providing care outside of usual opening hours. While there was some recognition amongst the senior team of the need for changes following the deaths of people waiting for care, there was no immediate action to identify the most at-risk patients.

Community-based mental health services for adults of working age

Requires Improvement

It was not always evident the provider identified and implemented learning from near misses. For example, a consultant providing care from outside of the UK found they could not contact 999 services from an international number when a patient experienced an acute crisis. As the appointment was outside of the provider's usual operating hours, the consultant could get find immediate internal support. While the consultant found alternative means of help and the patient had a good outcome, the incident highlighted a lack of risk assurance around certain aspects of providing care remotely. The provider had not identified this as an area for improvement and as part of our inspection we asked for an action plan of how the provider would address this risk in the future.

Clinical leads and team managers were responsible for sharing learning from incident outcomes and investigations. The incident lead disseminated this information to senior colleagues who then sent them onwards to their teams. While this system provided opportunities for staff to access up to date information, there was a lack of assurance that all staff had access to the most appropriate information for their practice. The provider recognised this gap and planned improvements as part of the implementation of PSIRF.

Is the service well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

There was a lack of assurance leaders had the skills, knowledge, and experience to perform their roles. They did not have a full understanding of the services they managed although they were visible in the service and approachable for patients and staff.

The registered manager was the chief assurance officer and formed the senior leadership team (SLT) with the medical director, clinical quality and governance lead, chief operating officer, clinical operations lead, and chief people officer. The SLT was in a transitional period as it underwent a significant restructure, including the recruitment of new senior managers, a new chief executive officer, and the implementation of new organisational structures.

At the time of our inspection the management structure was functional but did not have the capacity to safely manage the significant pressures and demand on the service. While the SLT had begun to implement strategies to address the impact of demand, the team did not have a substantive understanding of all the key risks to patients and staff. Strategies were in various stages between planning and early implementation and reflected an ambitious programme of improvement and expansion. However, there was a lack of early action to address urgent issues and risks that impacted patient safety and systems were not in place for the SLT to recognise all the areas in need of immediate action.

Clinical leads, deputy directors, and team or service managers led individual teams and areas of the organisation. For example, the titration team lead provided management support to prescribers and the learning and development manager worked across the organisation to support professional development. The existing structure meant each consultant had a clinical lead and deputy director for support and each manager had a departmental deputy.

Clinical specialties were organised into chambers, such as the psychiatry chamber. Clinical operations managers led specific chambers and worked with clinicians and operational support staff within each to provide leadership presence and support.

Community-based mental health services for adults of working age

Requires Improvement

The SLT restructure would result in a matrix management model with new compliance management in addition to the existing clinical management roles. The new model included senior staff with a wealth of experience in NHS commissioning and contract management and in large-scale clinical governance, which was an appropriate approach to addressing the capacity and risk management challenges faced by the provider. The provider's board had ratified the new structure in July 2023 and the SLT were in the process of testing and finalising implementation at the time of our inspection.

Staff commented variably on leadership in the annual staff survey. While most staff felt supported, recurrent themes included unstable or unclear management structure, a lack of management presence in team meetings, and inconsistent support. All staff we spoke with felt positively about their line manager and said they felt supported and proud to work for the organisation.

The SLT held weekly team meetings. Minutes showed consistently good attendance with a focus on risks, staff wellbeing, and capacity.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the service and its patients.

Staff worked within the provider's core values of compassion, accessibility, innovation, and high-quality care. The provider actively promoted and embedded the values and all staff we spoke with discussed how they were reflected in their work. Such awareness and satisfaction were reflected in the most recent staff survey in which 99% of respondents said they felt the provider operated within its core values.

The service had grown rapidly in the previous 18 months with patient numbers in excess of 150,000 and up to 2000 referrals per month. The service had not increased capacity to meet this demand and some departments were consequently overwhelmed with waiting lists. While staff told us they felt supported and did not work under excessive pressure, there was a lack of collective understanding of the wider implications of the waiting list on the organisation's vision. For example, the provider had not worked with other services or providers to reduce patient waiting times and instead focused on future improvements.

The chief technology officer (CTO) was in the process of implementing a wide-ranging new component of the provider's strategy, focused on technology-driven care. The transformation project aimed to ensure staff could work flexibly and the service could scale to new demands and anticipate upcoming risks and pressures. A new working group consulted with staff across the organisation to ensure testing and implementation were collaborative.

The SLT recognised the need for an improved safety and learning culture within the context of care providing remotely. A senior data scientist had recently joined the service and implemented a data driven care strategy that would ensure the digital referral and records system flagged patients at risk of deterioration to clinicians.

Culture

Staff felt respected, supported, and valued. They said the service promoted equality and diversity in daily work and they could raise concerns without fear.

All staff we spoke with described positive working relationships with colleagues and the SLT in a culture of support and value. Staff said senior colleagues were approachable and receptive to suggestions and ideas for improvement.

Community-based mental health services for adults of working age

Requires Improvement

Communication between teams worked well and the provider had built such systems to reflect the remote working nature of the service. The patient experience and SLT prepared newsletters for colleagues each month and all staff had access to an urgent online live chat system for on-demand, immediate support at any time the service was in operation.

The provider facilitated systems to support staff who wished to raise anonymous or confidential concerns. For example, a digital system enabled staff to submit concerns or comments, including whistleblowing, and a senior manager reviewed these. Where the individual submitting concerns wished to remain anonymous, the senior team responded to concerns in a monthly newsletter that included incidents, complaints, and learning. Staff also had access to an external, third-party system to report concerns where they did not feel able to raise them internally. All staff we spoke with knew about these systems and the options available to them. They said they felt confident raising concerns and worries and felt the senior team took such issues seriously.

While the confidential reporting systems reflected good practice, there was variable knowledge about the Freedom to Speak Up Guardian who was in post. Fewer than 50% of the staff we spoke with knew about this individual and it was unclear how the provider promoted knowledge and understanding of the role.

The SLT were embedding a new approach to culture and values following a period of challenge. An original founder of the organisation remained involved in board activity and new senior members of staff were working with staff in all roles to embed a culture of mutual respect and support. As part of this work, the senior team created an environment in which any member of staff could raise issues or concerns confidently and without any fear of repercussions. Staff we spoke with commented on this positively and said it worked effectively and they felt connected and invested in the service and their colleagues. For example, 1 individual told us, “This is an inclusive and innovative service, I’ve got my voice again.” Another member of staff said, “There’s no obstacle to change here, everyone wants this [the service] to work well for patients.”

There was a significant breadth and depth of mental health care experience across the entire provider team. This included clinicians with backgrounds in acute mental health care and treatment and senior staff with experience in NHS services and commissioning. Staff described such expertise positively. For example, 1 member of staff said, “There’s no ‘us and them’ with anyone across the organisation. Operations, technical staff, administration staff, clinical staff…everyone works well together and the executive team [SLT]; we incorporate each other as much as we can.”

The provider had a comprehensive rolling programme of equality, diversity, and inclusion. Staff rated this highly during our discussions and said they were pleased with the organisation-wide focus on recognising and celebrating diversity. This included SLT action to address prejudice or bigotry when it happened, which staff said made them feel safe and able to work to the best of their abilities. Staff reported high levels of satisfaction with diversity and inclusion in the 2023 survey, in which 99% of respondents said they were happy with the provider’s approach. A multidisciplinary equality and diversity committee worked across the provider’s structure to ensure new policies, guidance, and practices were equitable.

Staff told us about a ‘shout out’ system that enabled them to nominate colleagues for work well done. They said they appreciated the system because it meant reward and recognition was peer-led and included everyone in the organisation.

The SLT encouraged consultants to engage in enrichment projects such as teaching and research relating to their continuing professional development (CPD). Nurses said opportunities for CPD were adequate for their role and responsibilities.

Community-based mental health services for adults of working age

Requires Improvement

Governance

Governance processes did not always operate effectively at provider level and performance and risk were managed inconsistently, with

The SLT used a series of planned meetings to monitor and manage clinical governance, including incidents, safeguarding trends, and pressures on the service. Clinical leads and heads of department joined meetings to represent their teams and ensure the provider had access to all the information needed to run the service. Clinical staff used a multidisciplinary clinical governance process to ensure patients with complex needs received appropriate coordinated care.

The rapid growth and nature of the service, with patients under the substantive care of other organisations and receiving specialist, targeted care with this provider, meant it was often unclear which organisation was responsible for a patient's needs and risks at any given time. For example, the provider had submitted statutory notifications to CQC regarding the unexpected deaths of patients but had taken several months to send these in some cases. Patient deaths had occurred whilst patients were waiting for mental health care following referrals from NHS providers and had not been under the direct responsibility of this organisation. However, coroners and other professionals had been unable to clearly navigate the complexity of areas of responsibility to investigate deaths. This reflected a clinical governance and oversight system that had not kept up to date with demands on the service.

All clinical care was delivered remotely, and clinicians typically used home office space from which to carry out appointments. While the provider required staff to have a private space that ensured confidentiality, there were no systems or checks in place to provide assurance.

Some areas of clinical governance were under sustained pressure from demands on the service. For example, the most recent key quarterly audit through which the provider gained assurance of the quality of patient records was cancelled to a lack of capacity amongst the consultant body.

Prescribing staff posted completed prescription slips to patients' home addresses using secure delivery. However, the provider did not audit this system to ensure the correct patient always collected the correct prescription slip. This meant the SLT did not have assurance of good governance around safe and secure prescribing.

Management of risk, issues, and performance

The provider did not have effective systems to manage risk and performance and there was limited understanding of the impact on patient care.

In the first 6 months of 2023, the service received 54,193 referrals, of which 92% were 'right to choose' referrals from NHS contracts. In June 2023, the service received 23,000 telephone calls from patients or referrers. This reflected the scope of demand on the service, which was a key risk because it far exceeded capacity, leading to significant waiting lists. The SLT had implemented strategies to address the risk and reduce waiting times. These included changing the recruitment process for consultants to offer fully employed posts with predetermined hours and a new automated administration system to reduce consultant time spent on administrative duties by up to 50%. Such work was in progress at the time of our inspection and needed time to be fully developed and implemented.

As part of this work, liaison nurses increased involvement with community care providers to provide a collaborative, systems-based response to patients at risk of deterioration or crisis. This was a good response to patients at risk from the impact of an extended wait although could not include all those with increased risk.

Community-based mental health services for adults of working age

Requires Improvement

The service had improved how they communicated with patients waiting for an initial assessment and provided details of what to do if a patient's needs changed or their condition deteriorated. Most patients were seen through NHS "right to choose" contracts, which meant they chose this provider after their GP or other referring professional identified a need for care. When the service provided a written acknowledgement to patients that their referral had been accepted, staff added a statement to manage expectations of waiting times. They also provided instructions on managing a deterioration of mental health, including contact details for crisis support organisations local to the patient's home address.

Under commissioned 'right to choose' contracts, the service was unable to cap or limit referrals regardless of the size of the waiting list. This significantly increased the risk for vulnerable patients as waiting times increased. To manage this risk the provider implemented a range of strategies. For example, they formed a new team of nurse coordinators who contacted patients during their time on the waiting list to check if their condition had worsened and ensure this was the most appropriate service for them. The service added contact details of local crisis support services to the acknowledgement e-mail sent to patients accepted for assessment as well as clear wording that in urgent or emergency situations, patients should contact 999. While this reflected good practice, the service did not have sufficient staff to check the immediate risks for each referred patient. Instead, staff used a sampling approach.

After our inspection we asked the provider to address this urgently as it was an unmet and significant risk. The SLT implemented a management plan that included a temporary suspension of accepting new patients through the NHS 'right to choose' system along with a new urgent governance system to provide assurance of risk management.

The service had improved screening and triage processes to reduce the risk of inappropriate referrals. Staff obtained as much information as possible from referrers about known risks to each patient and used this to decide if it was safe and appropriate for the patient to be placed on a waiting list. They communicated with referrers to ensure they understood the scope of the service and did not refer patients in crisis or with acute needs.

While demand on the service exceeded capacity, consultants sought opportunities to change working practices and improve the timeliness of care. For example, a consultant who specialised in psychodynamic medicine implemented Schwartz rounds in the service, a multidisciplinary approach to reviewing and learning from patients with the most complex or unusual needs.

The provider understood the potential risks associated with clinicians working remotely and alone from home. The SLT enforced a zero-tolerance policy for abuse and discharged patients who threatened staff. Staff had access to a support network in the event they were abused or threatened, and a senior member of the team facilitated time away after such incidents.

There were gaps in risk management assurance for patients who were difficult to contact. For example, there was no plan of care for patients who disengaged from the service or who did not respond to follow-up requests 12 months after discharge. We spoke with consultants about this who said all patients had capacity to consent and to make their own decisions, which meant there was no requirement for advanced follow-up attempts. However, the provider did not have an overarching system of assurance of the safety of these patients.

Demand that exceeded capacity had a significant impact on the service. For example, the patient records system showed individuals who had not been contacted or heard from in over 18 months as 'active'. These patients had no recent risk assessments or care plans but were included as part of the overall caseload. There was no process in place to

manage such patients and the provider did not have assurance of effective clinical governance or risk management. In the same period, private patients had self-referred and received no reply for 2 months. The service contacted them and estimated a delay of 7 months for an initial assessment. Patients underwent an initial assessment 11 months after they first contacted the service and began to receive treatment 18 months after they had self-referred.

The SLT had an uneven understanding of risks. The overriding areas of priority were improving sustainability and managing growth and digital transformation. Part of the provider's long-term sustainability plans included the development of a non-medicinal service for use after diagnosis, such as group therapy. The service had launched the first such service commissioned by an NHS trust and planned to use the results to refine the approach nationally. Such areas reflected innovation and future planning but excluded pressing, urgent gaps in assurance and risk management.

The provider worked with NHS trusts and commissioners to address risks caused by a lack of capacity in partner organisations. For example, the service provided an older person dementia assessment through a clinical pathway commissioned by an NHS trust. Most patients seen required a computed tomography (CT), but this was provided by a separate provider that did not have enough CT equipment to meet patient needs. This resulted in a significant backlog but was outside the control of this provider.

The SLT used a corporate risk register to track themes and individual risks. Key risks reflected the challenges associated with the rapid growth of the service and included outdated systems and processes and governance that had not kept up with the pace of growth. At the time of our inspection there were 23 risks. Each had a named owner and documented regular progress updates.

Information management

Staff managed information in line with national standards.

Staff used an end-to-end encrypted virtual consultation system to meet patients and maintain medical records. This included live technical support, pre-diagnostic support information and advice through online support forums and an app-based self-reporting tool. The system maintained voice records of all patient appointments, which enabled consultants to transcribe notes and maintain a continuous record of outcomes and treatment. The service had back-up systems and security contingency in place.

A designated data protection officer managed information security and safety and an external specialist provided cybersecurity guidance and protection. They provided on-demand guidance and support for staff and periodic training. This reflected the digital nature of the service and ensured staff used systems appropriately and safely from their home offices.

Medical secretaries were restructuring how they worked, to streamline communication and appointment processes. Part of the wider strategy aimed at reducing waiting times and increasing capacity, the team were changing how they triaged and processed referrals and tasks to reduce the time burden across the system.

Computer systems monitored where and when patient records and other sensitive information were accessed. This was part of a wider safety and security system to ensure access to records took place only when needed and appropriate.

Improvements in the electronic patient portal meant safeguarding alerts and referrals were linked directly with care and treatment plans. Such system upgrades meant staff could more easily access all the information needed for patient care.

Community-based mental health services for adults of working age

Requires Improvement

Engagement

Managers engaged other health and social care providers to facilitate shared care systems that promoted integrated health and care systems across local populations. Managers from the service participated actively in cross-agency work.

The SLT engaged with staff through bimonthly information sharing meetings, monthly group supervisions, and regular 1-to-1 supervisions. An internal communications team ensured staff were kept up to date with changes in the service, celebrations of good news, and learning from incidents. They provided details of changes to policies and practices, including those influenced by national and international factors, such as updates to guidance and best practice.

Staff provided care to patients registered across significant geographic areas, with referring NHS trusts and Integrated Care Boards (ICBs) covering most of the UK. The service encountered wide variances in understanding and expectations of the scope of the service across ICBs and referring services, which impacted the ability of staff to provide consistent care. For example, some NHS trusts allowed the prescribing of melatonin for their patients and others did not. Many trusts had different interpretations of best practice care for patients living with attention deficit hyperactivity disorder (ADHD) despite the role of this provider in making decisions about individual treatment. In the absence of specific national guidelines, this led to a complex operating environment in which the service needed to meet different operating practices and care standards. The medical director worked with clinical colleagues in other organisations to ensure consultants and prescribers adhered to local rules. Senior governance staff worked at contractual level to ensure NHS trusts and ICB commissioners understood the scope of the service.

The medical director, who was the provider's Controlled Drug (CD) Accountable Officer, worked with a CD intelligence network as part of a commitment to engaging with other providers and commissioners to ensure prescribing standards met patient needs and safety standards. For example, prescribing standards that were acceptable in one ICB area were cause for concern in others. Differences in standards included amongst regional GP groups in single ICBs, such as a region where some GPs would not carry out electrocardiograms (ECGs) required for ongoing titration safety whereas others would do so. The medical director acted on such complexities and the lack of consistency and ensured policies and standard operating procedures were based on evidence from organisations expert in the specific field of care.

Under existing NHS 'right to choose' contracts, the service was unable to cap the number of referrals it could receive or the size of its waiting list. The newly formed governance leadership team were negotiating with NHS colleagues to streamline this process and better manage demand. This included implementation of access to shared care records to improve oversight of patients who received care from multiple providers.

The service engaged with NHS trusts and other agencies nationally, including the National Institute for Health and Care Excellence (NICE) to develop alternative approaches to treatment. This resulted from engagement with patients, around 25% of whom said they would prefer therapy to medication.

The service asked all patients to complete a feedback questionnaire once their care had commenced, using a 5-point star system. Where patients scored less than 4 stars, a senior member of staff contacted them to gain more detailed information about their experience, which the service used for improvement.

A diversity, equality, and inclusion group operated across the organisation. The group provided peer support following challenges and upsetting events and prepared strategies to improve accessibility for staff with needs such as neurodiversity.

Community-based mental health services for adults of working age

Requires Improvement

The provider had operated an annual staff survey since 2021 and published a detailed report on participant responses, separated by clinical or non-clinical staff group. While the resulting analysis was comprehensive, there was limited assurance the SLT took meaningful action based on feedback. For example, the most recent survey results compared year-on-year results including free text comments. A recurring comment noted the demanding level of bureaucracy involved in some aspects of the respondents' roles. The SLT response linked the similar comments and suggested the same respondent had made them in 2 consecutive years and did not indicate an approach to understand them in more detail or address them. While most written comments were positive about working processes and structures, this example reflected a lack of capability at provider level to address staff concerns.

While staff surveys indicated staff overall were happy with their work, the provider had not established substantive measures to address themes of anxiety such as being overwhelmed with administrative work, sustainability of the service, and concerns about balancing NHS work with a commitment to this service.

Learning, continuous improvement and innovation

The chief technology officer (CTO) was a practising consultant and was developing innovative technology-driven solutions to better manage waiting lists and demands on the service. They were active in the international development of artificial intelligence systems in healthcare, including with UK statutory bodies. Developments in the process of proof-of-concept testing included an artificial intelligence system that could generate a consultant referral letter as an appointment progressed, with final checking and approval by the clinician. The service accelerated this development following our inspection to address significant waiting times for appointments.

Technology-led improvements planned for the service took place within clear safety and data protection policies and systems. This included a new clinical safety team with 2 senior clinical safety officers and a non-clinical risk management officer. Work underway at the time of our inspection included development of risk-assessing software for patient safety, which the CTO and their team tested in workshops.

Digital development work included broad improvements to auditing systems, which were mostly led by staff-intensive, manual processes. A new digital auditing system enabled staff to review treatment plans and discharge letters to ensure they met patient need and to identify potential issues, such as letters that contained large amounts of identical information. This reflected a significant improvement to quality assurance tools.

The senior clinical team had created new opportunities for junior doctors and specialist registrars, professional groups not normally involved in the service. This included special interest CPD sessions and ADHD learning development opportunities. The new programme would improve regional specialist knowledge about ADHD service provision and increase access to care for patients. The programme complemented an existing relationship with teaching hospitals that enabled medical students to carry out safeguarding and incident learning projects with the service.

The seniority and experience of clinical staff was unusual in a service designed for low-risk patients. For example, consultant psychiatrists were typically accessible to people through the NHS only when they received care as inpatients. The team recognised that this provided an innovative model of care unavailable that impacted communities.

Specialist community mental health services for children and young people

Inspected but not rated

Safe	Inspected but not rated
Well-led	Inspected but not rated

Is the service safe?

Inspected but not rated

We have not previously inspected this service.

Safe environments

The service did not have clinical premises. All care was delivered remotely using digital video software.

Clinicians delivered clinical care remotely using a secure digital telemedicine system. Staff understood the risks to children and young people (CYP) in the use of such systems and managed these well. They required a responsible adult, such as a parent, to be visibly present during consultations for patients aged under 13 years old. For patients aged between 13 and 18, consultants worked within risk assessments and the Gillick Competencies and Fraser Guidelines to establish how to carry out treatment appointments safely.

Please see the main report.

Safe staffing

The service had enough staff, who knew the patients and received basic training to keep them safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.

Consultant psychiatrists led services for children and young people (CYP). Consultants were experienced and typically had a lengthy service in the NHS with some individuals holding more than 20 years in the field. While the service did not employ or sub-contract paediatric nurses, consultants worked alongside NHS nurses from the referring trusts to coordinate care and ensure they had access to resources and pathways.

A lead consultant psychiatrist managed the CYP service. A team of child and adolescent consultants for attention deficit hyperactivity disorder (ADHD) diagnoses worked with specialist independent child and adolescent mental health services (CAMHS) nurse prescribers, who led the titration service. Staff worked with specific commissioned areas. For example, nurses worked with both NHS and private patients and whilst CAMHS clinicians worked only with patients referred under NHS arrangements.

All consultants were registered with the General Medical Council (GMC) and the provider acted as a designated body if the individual worked independently of the NHS. Where consultants also worked for the NHS, they completed an annual appraisal with their responsible officer and this provider reviewed the outcome annually.

Consultants and nurses managed their own schedules and the administrative team provided scheduling support. It was common practice to offer clinical sessions at evenings and weekends, which met patient demand outside of education commitments.

Specialist community mental health services for children and young people

Inspected but not rated

Mandatory training

Staff had completed and kept up to date with their mandatory training, which was standardised across the provider. In the 2023 staff survey, some staff noted the training was too generic to meet the needs of the CAMHS service. It was not evident from the training programme that the provider had acted on feedback to tailor the training programme. However, all staff we spoke with told us they felt the training was suitable for their role.

Please see the main report.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients. They responded promptly to sudden deterioration in a patient's health.

Assessment of patient risk

Staff completed risk assessments for each patient on referral and reviewed this regularly, including after any incident. The initial assessment included a mental state assessment and discussions with others involved in the patient's care, such as school nurses.

While risk assessments were structured, the provider did not require the use of a recognised tool. For example, consultants documented and formulated risks in their initial letter to referring clinicians, which established a plan of care.

Consultants used a generic crisis plan to support multidisciplinary care based on individual patient need. The service did not provide specialist crisis support and used an urgent referral pathway based on individual NHS contracts in such cases. Where a private patient experienced a crisis, the consultant accessed the patient's local services such as GPs or social services and provided an urgent referral.

The service required patients, including private patients, to be registered with a GP prior to commencing assessment and treatment. Consultants required a written patient summary from their GP along with parental consent for treatment. This formed an initial risk assessment system to ensure the service could meet patient need.

Management of patient risk

Documentation of continuous, effective management of risk was inconsistent. For example, in 1 patient record, the consultant's written assessment documented risks relating to anger and violence. However, a separate risk assessment stated there were no risks associated with the child and that there were no safeguarding risks. In another record it was not clear if the consultant had included a patient's claims of intended sexual abuse to their GP at the point of discharge.

Despite some inconsistencies, staff worked to secure multidisciplinary clinical support for patients with complex needs. For example, they worked with an NHS trust to secure the input of a specialist in obsessive compulsive disorder (OCD) to support coordinated treatment for a CAMHS patient. Such work demonstrated timely communication and risk management in the best interests of patients.

There was a lack of assurance the service maintained appropriate standards of risk history after a patient was discharged. For example, the service discharged 1 patient with a history of violent threats in their community to the original referrer. However, there was no clear follow-up with the referring service, and we could not establish if staff had highlighted known risks.

Specialist community mental health services for children and young people

Inspected but not rated

The referring NHS trust was responsible for managing patient risk whilst they were waiting to be seen by this service. Staff did not provide a crisis service and in the event a patient's needs became urgent whilst they were waiting for assessment, the responsible NHS trust suspended the referral until more suitable care had been provided.

Staff managed risk based on the patient's age and individual need, such as their ability to consent and to understand the nature and goals of their treatment. Where teenage patients wished to attend appointments without a parent present, the consultant risk assessed this to ensure it was appropriate.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named safeguarding lead and a doctor for child safeguarding.

Staff received training on how to recognise and report abuse, appropriate for their role. All clinical staff completed CAMHS level 3 safeguarding training and undertook regular updates. At the time of our inspection 100% of staff were up to date.

The provider's safeguarding policy included guidance on providing care for young people between 13 and 16 years old without parental consent in line with the Fraser Guidelines and Gillick Competencies. The service required a parent to join the initial assessment in all cases. Where they identified a patient at risk for problematic sexual activity or substance use, staff met with the patient alone and with the parent alone. This reflected good practice and meant staff ensured young people received appropriate advice in relation to issues they disclosed outside of mental health needs. All staff we spoke with demonstrated a good understanding of the policy and escalation pathways, including for urgent needs and care provided to young people under the age of 13.

The clinical team were leading a CAMHS consent inquiry to explore options for proxy consent when a patient's parents were separated or 1 was unavailable. The team often worked closely with school nurses and the inquiry into proxy consent considered options for information sharing.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. However, there was a lack of assurance safeguarding concerns were consistently followed up. For example, a consultant had documented a series of safeguarding concerns regarding a patient who subsequently disengaged and whose parents were not contactable. Staff had not attempted to contact other agencies involved in the patient's care and there was no conclusive follow up to ensure the patient had the help they needed.

There was a lack of assurance that consultants appropriately documented and referred safeguarding risks identified in patient assessments. For example, 1 patient record indicated a risk to the child's siblings due to violent tendencies. However, the consultant noted no safeguarding risks despite the presence of younger children in the household. In another example, a consultant had not updated a patient's risk assessment notes when they had made allegations of abuse and a parent had disclosed intent to self-harm. While the consultant had contacted the patient's GP and asked them to liaise with the local safeguarding team, there was a lack of assurance of consistent support.

The provider's safeguarding lead was a qualified trainer and recognised nationally in safeguarding boards. They supported clinical colleagues with referrals, including in urgent situations, and helped to write the level 3 training programme. Staff spoke highly of this individual and provided numerous examples of receiving support and guidance during complex cases.

Specialist community mental health services for children and young people

Inspected but not rated

Staff copied locality safeguarding teams in all documentation and referrals that involved a safeguarding concern. For NHS patients, they also copied the patient's referring trust.

Staff access to essential information

Staff kept detailed records of patients' care and treatment but there were inconsistencies in the documentation of risks.

Patient notes were comprehensive, and all staff could access them easily through the provider's secure online portal. However, there were inconsistencies in the documentation and tracking of individual risk factors. For example, the records of 1 patient included a narrative of aggression and threats of violence but the clinician documented elsewhere in the record that no risks were present and there were no safeguarding needs. This contradiction of evidence reflected patient records that relied on free text from consultants rather than the use of standardised systems that could be adapted to individual patients. In another example staff did not consistently document action taken to support a patient with known risks when their parents stopped engaging with the service. For example, at the point the patient was considered discharged, staff noted there were no remaining risks despite no evidence previous risks had been resolved.

Other records we looked at included more consistent documentation including a record of multidisciplinary agency involvement but lacked evidence of follow-up when patients and their parents could not be contacted. This meant there were gaps in assurance of consistent risk assessment practices.

The patient records system was encrypted and secured with back-up systems. The provider monitored access and restricted this securely, although did not carry out home office assessments of clinicians' working environments.

Medicines management

The service used systems and processes to safely prescribe medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe medicines safely. They worked transparently with each patient's GP and began treatment only when the GP agreed. This reflected standard CAMHS working practices.

Staff kept good standards of documentation for patients who transitioned from CYP to adult care. This included baseline physical health details and changes to prescriptions and treatment plans.

Staff reviewed each patient's medicines regularly and provided advice to patients and parents about their medicines. Consultants sometimes prescribed outside of National Institute for Health and Care Excellence (NICE) guidance such as where medicines were off licence or there was no formal guidance on usage. In such cases consultants worked with the CAMHS lead to develop internal policies that adhered to the complexities of each NHS contract. For example, most NHS trusts allowed consultants to prescribe melatonin but 1 trust required this to be prescribed by a GP.

Staff completed medicines records accurately and kept them up to date. All records we looked at included a comprehensive prescribing rationale. Staff sent prescriptions by tracked postal delivery but there was no centralised tracking or auditing system in place. This meant the service did not have assurance about the security and reliability of the prescribing system.

Specialist community mental health services for children and young people

Inspected but not rated

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines and reviewed the effects of each patient's medicines on their physical health in line with NICE guidance. For NHS patients, staff adhered to the local prescribing formulary as a strategy to encourage GPs to adopt shared care arrangements after patient discharge.

Consultants changed patient medicines in line with individual needs. For example, they stopped or changed medicines when patients experienced unplanned side effects such as weight loss.

Track record on safety

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them. They raised concerns and reported incidents and near misses in line with the provider's policy. However, the reporting system was outdated and relied on staff e-mailing reports followed by the use of a spreadsheet for manual tracking.

The senior team were in the process of implementing and embedding a new centralised incident reporting system that would bring the service in line with the system used by the integrated care boards (ICBs) in the areas in which the service operated.

Please see the main report.

Is the service well-led?

Inspected but not rated

We have not previously inspected this service.

Leadership

Leaders had the skills, knowledge, and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

A clinical lead, with support from their deputy, led the consultant and nursing teams and a child and adolescent mental health services (CAMHS) service manager provided management oversight of contracts with NHS trusts. This team worked within the provider's overarching leaderships system and ensured the children and young people's (CYP) service was represented in leadership and governance processes.

The provider's senior leadership team (SLT) had overall responsibility for all services.

Please see the main report.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Specialist community mental health services for children and young people

Inspected but not rated

The provider's overarching vision and strategy applied to all services and staff understood them well. The CYP service was distinctly separate from adult care although significant areas of work and provider structure overlapped. The CAMHS service manager led their team within an ethos of care for young people and adapted the service to reflect the provider's vision whilst developing care and treatment in this specialty.

Please see the main report.

Culture

Staff felt respected, supported, and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise concerns without fear.

While staff mostly reported and spoke positively about the provider's approach to equality and diversity, CAMHS staff noted, in the 2023 staff survey, the service was not specifically represented on the equality and diversity committee. While the SLT acknowledged the comments, staff had raised similar comments in the 2022 staff survey without action. This reflected a lack of evidence staff survey results were acted on rather than simply reported or acknowledged.

Please see the main report.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance was managed well.

The provider delivered CAMHS care for NHS patients in line with service level agreements. Care delivered to private patients was similar and included a broader scope for diagnostics and prescribing as staff used the provider's own policies. The senior service team worked closely with NHS providers to manage waiting times and referral rates, which were manageable and steady at the time of our inspection. They met with counterparts in referring trust CAMHS teams to ensure the service met patients' needs and clinical subspecialties had the necessary resources and staff with expertise in place.

The senior team managed governance at service level through a structure of meetings and reviews, including with non-clinical operations and administrative staff who provided essential support. Where concerns or challenges impacted patients or the service beyond CYP care, they worked with SLT colleagues at provider level to coordinate solutions.

Please see the main report.

Management of risk, issues, and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The senior team recognised the risks of rapid expansion and managed demand for services in line with staffing capabilities and capacity. CAMHS services operated to supplement NHS care due to waiting list pressures and staff understood the anxiety patients and their parents often presented with after waiting for treatment. Private patients typically chose this service as an alternative to CAMHS due to waiting lists in their local area and staff managed caseload to ensure it enabled appropriate levels of care for each patient.

Specialist community mental health services for children and young people

Inspected but not rated

Staff acted on a trend for the parents of private patients to expect medicine prescribing without an assessment. The team worked together to ensure prescriptions were clinically necessary.

Processes to support staff and patients during an emergency in a session were limited. The CAMHS lead worked part time and their deputy was based overseas, with a 5-hour time difference with the UK. Senior staff said there was usually someone available for staff to contact in an emergency, but this was not a formal process.

Information management

Staff managed information in line with national standards.

Staff adapted information sharing based on individual patient need and the other professionals involved in their care. For example, school nurses based in private schools were frequently involved in care, such as daily observations for patients prescribed anti-stimulant medicines.

Please see the main report.

Engagement

Managers engaged other health and social care providers to facilitate shared care systems that promoted integrated health and care systems across local populations. Managers from the service participated actively in cross-agency work.

CAMHS consultants used a monthly multidisciplinary meeting to review planned care and the needs of patients with complex conditions. Nurses recently joined the monthly meeting and said this worked well to coordinate good standards of care.

The senior team maintained good relationships with NHS CAMHS services, who commissioned the care pathway. Each trust worked to different standard operating procedures and prescribing guidance and the service manager ensured the team had an up to date understanding of each. For example, each consultant delivered care to patients from different NHS services, which meant they worked to different standards of treatment and prescribing. Engagement processes meant the provider had continuous oversight of changes and differences between referring services.

Learning, continuous improvement and innovation

The service was forward-looking by nature and sought opportunities to reduce waiting lists for NHS patients. The service was finalising a new contract with an NHS trust to expand the service to provide autism spectrum disorder (ASD) care in addition to the existing ADHD pathway.

The service sought methods of ensuring continuity of treatment for patients with unpredictable lives. For example, a patient who received treatment relocated abroad and under a government programme were entitled to NHS care. The provider liaised with the original referring organisation and the employer of the patient's parents to coordinate access to care.

The service had developed a transitional care pathway for private patients who turned 18 years old during treatment. This addressed a gap in services as transitional care more commonly occurred amongst NHS patients. Staff worked with individual patients to ensure continuing care met their needs.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service did not have a clear, consistent understanding of changing or escalating risks experienced by patients awaiting assessment and treatment. • The service did not have effective risk management systems in place for clinical staff providing care outside of the core working hours of managers and senior staff. • Staff did not use a consistent approach to risk assessments with patients. • The service did not have an effective system to follow up or act upon known safeguarding risks when patients disengaged and did not respond to contact. • The service did not ensure learning from near misses or incidents was consitently communicated to all staff. • There was no monitoring or assurance that consultants completed care and treatment records in a timely manner.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • Risk management, quality assurance, and clinical governance systems did not meet the needs of the service, its patients and its staff. • Auditing systems did not have the capability to provide security assurance of prescriptions sent by individual consultants to patients and pharmacies. • The service did not ensure accountability for patients who are waiting for assessment or treatment was clearly defined.

This section is primarily information for the provider

Requirement notices

- The service did not have assurance that clinical staff providing care remotely from home always followed good standards of confidentiality.